Commentary on: The Opioid Epidemic: Who Is Responsible and What Is the Solution?

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Nadeau et al highlight the extent of the opioid crises in the United States and address their protocol at the University of Minnesota School of Dentistry to reduce the number of opioid prescriptions by more than 46% over 1 year.¹ They also point out that dentists and oral surgeons are responsible for the majority of opioid prescriptions to minors, and cite that 99.2% of dentists report the used of various opioids for procedures, with hydrocodone and oxycodone being commonly used. They are to be commended for their significant reductions over a short time, and their efforts to make health professionals aware of the need to change prescribing practices.

Analogies have been made to the “#Me Too” movement of needing to break the silence and use peer support to speak up and change our practices regarding the opioid challenge.² This comes at a time when another Minnesota randomized trial compared the use of nonopioids for pain management to opioids. The study found that the control of the pain intensity was better in the nonopioid group and the adverse medication symptoms higher in the opioid group.³

To truly address the issue of the opioid crises it may be worth exploring some of the causes. Some have blamed the greed of the pharmaceutical companies. The governor of Minnesota has proposed to tax prescription opioids a penny on each milligram of active ingredient in a pain pill. At least 12 other states have considered an opioid tax in recent years to raise revenue to address the fallout of the opioid epidemic.⁴ Numerous lawsuits have been filed against the pharmaceutical companies, but prosecutions have been a challenge.⁵

Studies have shown that 98.6% of surgical patients are prescribed opioids.⁶ There are strong correlations made between early opioid prescribing and the likelihood of long-term use of narcotics.⁷ Six percent of patients who are prescribed opioids continue to use opioids 150 days later⁸ and 83% of those who use heroin started on oral opioids.⁹

A question that needs to be addressed is how this has become such a great problem in the United States? It is easy to blame prescribing practices of the doctors, and 33% of the public place the blame on their inappropriate prescribing.¹⁰ Many of us have assumed that this was entirely the problem. An interesting article was written by an American in Germany who had a laparoscopic hysterectomy and was shocked to find that she would be given ibuprofen and no hydrocodone which she requested.¹¹ At the end of the article, she felt that she had done fine without an opioid. It appears that Americans have developed different perceptions and expectations from much of the rest of the world regarding their pain management. There may be very good institutional reasons for this evolution, and for the reasons that a very small percentage of the world's population in the United States use the majority of the world's opioids.

In 1990, Mitchel Max strongly advocated for the improvement of analgesic treatment for pain,¹² and cited a publication which concluded addiction was rare in patients treated with narcotics.¹³ This helped inspire a movement over the next decade for better pain control. Hospitals and hospital administrators in the United States live in fear of a regular review by the Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO) which accredits health care organizations a minimum of every 39 months. The Centers for Medicare and Medicaid Services (CMS) sets standards for hospitals and the Joint Commission is one of the bodies that certify hospitals. Without these certifications, the hospital will lose accreditation and federal dollars. Unfortunately, in 2001, JCAHO decided to get into the business of mandating the standards of pain management.¹⁴ Their implementation stated “Pain is considered a ‘fifth’ vital sign in the hospital's care of patients.”¹⁵ David Baker goes on to say that in 2002 this was revised to say “Pain used to be considered the fifth vital sign.” By 2004, “this phrase no longer appeared in the Accreditation Standards manual, although the phrase remained in some Joint Commission educational materials

for several years after that.”¹⁵ Though the Commission has been working on projects to revise the assessment of pain, it appears that there will still be the expectation that pain needs to be properly addressed for accreditation purposes. Without clear new guidelines, hospitals continue to use pain as the fifth vital, with patients routinely being asked to score their pain on a scale of 1 to 10. This helps set the immediate expectation of a patient in the postoperative period that his or her pain should be managed, with many of our patients feeling the medications should be adequate so that their pain is negligible. It is not coincidental that the significant surge in opioid prescriptions correlates very nicely with the initiation of pain as the fifth vital.

In the past, CMS linked reimbursements to patient's satisfaction with pain management. Letters from Physicians for Responsible Opioid Prescribing (PROP) and other groups called on the Joint Commission and CMS to scrap pain as the fifth vital sign,¹⁶ and the American Medical Association recommended that pain be dropped as a “fifth vital sign.”¹⁷

After receiving considerable criticism, CMS announced it would remove and revise questions assessing pain management. New guidelines for pain surveys will begin in October 2020.¹⁸ The Medicare questions that had been used until 2017 included:¹⁹

“During this hospital stay, did you need medicine for pain?”

“During this hospital stay, how often was your pain well controlled?”

“During this hospital stay, how often did the hospital staff do everything they could to help you with your pain.”

It is easy to see how with the past requirements of the Joint Commission and CMS, many of which have continued in our hospitals, American patients have been “educated” to have unique expectations regarding pain management compared with many other parts of the world. The doctors have been expected to prescribe according to these expectations. They have also been told by many larger institutions that their reimbursement will be linked to patient's satisfaction. Finally, our health care professionals are now falling victim to the threat of on-line reviews, for which they see no recourse if a disgruntled patient who did not receive a desired prescription decides to “get even” and give them a poor review.

Health policy experts recognized and documented concerns for this epidemic over a decade ago.^{20,21} It is true for socioeconomic and other reasons that pain treatment is inaccessible for many impoverished parts of the world.²² Nevertheless, it is clear that other advanced countries like Germany have not developed the problems of opioid misuse that we see in the United States, and the problem of expectations cannot be correlated with the socioeconomic conditions of a country.^{23,24}

Nadeau et al are to be commended for their work, significantly curtailing opioid use at their institution.¹ Hospital systems and regulatory bodies need to better acknowledge their roles in helping create the opioid epidemic, and recognize that pain is a symptom and not a vital sign. Solutions in North America need to include their help in changing patients'

expectations. We cannot continue to implement policies suggesting that if patients are experiencing pain, they are receiving poor medical care from their providers.

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